AUTHORIZATION TO REVOKE A PREVIOUS AUTHORIZATION

Health Plan of San Joaquin | Mountain Valley Health Plan

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires that you notify Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") in writing that you are revoking a previous authorization to access your health information.

This authorization is not valid if this form is not filled out completely. Health Plan may already have filled in some answers. After you fill out the form, mail or take it to Health Plan at one of the following locations:

7751 South Manthey Road **French Camp, CA 95231-9802**	**1025 J Street** **Modesto, CA 95354**

You may also fax the form to: **1-209-461-2550**

1. Person Revoking Authorization:			
Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**Zip Code:**
Health Plan ID Number:			

2. Revoke Authorization:

☐ I revoke my authorization for Health Plan to use and disclose my health information as described in my original authorization:

a. Is a copy of the original authorization attached?

☐ If **YES**, skip to question 3
☐ If **NO**, you must complete question 3

3. Original authorization (must complete if you selected "No" in question 2.a):

a. Date of original authorization:

b. Describe the information that the original authorization applied to:

Print Name of Member

Health Plan ID Number

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c. List the person or company the original authorization applied to:

☐ Grandparent(s). Name(s):_____

☐ Non-custodial parent or stepparent(s). Name(s):_____

☐ Other relative, companion or friend of the member.

Name: _____ Relationship: _____

☐ Member's Attorney. Name: _____

☐ Other. Name: _____

4. Signature:

You have the right to refuse to sign this form. If you refuse to sign this form, your original authorization will not be revoked. Your refusal to sign this form will not affect your treatment or eligibility for benefits, or the Health Plan's payment of services.

If you do sign the form, you have the right to change your mind at any time. You will need to do this by writing to Health Plan. Your request will be effective on the date we receive it, but we will not be able to stop any action that may have already taken place.

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Signature of Member **Date**

5. Personal Representative:

If you are not the member, please print, sign and date below and describe your relationship to the member.

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Print Name of Personal Representative

....

Signature of Member **Date**

Note, if you are acting as the Personal Representative of a member, please tell us your relationship to the member. You may be required to show us proof of your legal permission to act for the member:

☐ Parent of Minor Child ☐ Legal Guardian ☐ Power of Attorney ☐ Other (describe):

_____

If you are filling out this form because you want the Health Plan to revoke authorization to another person or company, you should make a copy of it for your records. Should you have any questions about this form, please contact our Customer Service department at **1-209-942-6320**.

Print Name of Member

Health Plan ID Number